I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Financial accountability, or integrity, is a joint responsibility of the Division of Developmental Disabilities (DDD) with assistance from the Division of Public Health (DPH), and the Department of Health and Human Services (DHHS) Financial Services.

DDD is responsible to ensure the integrity of the service authorization and claims processes. DDD staff authorizes services, verifies individual claims, corrects suspended claims, and tracks the participant's utilization of waiver services.

A vendor web-based authorization and case management system identifies inaccurate authorizations, claims and trending data, and DDD supervisory and management staff utilize this data to determine follow up with service coordination staff to correct errors in service authorizations or conduct monitoring activities to determine if authorizations are sufficiently linked to service delivery. This data may also lead DDD staff to conduct financial reviews of provider claims when concern is raised through monitoring, certification activities by DPH or complaint investigations.

The DHHS Financial Services division tracks audit reports, operates the cost allocation plan, prepares and monitors budget projections for the Division of Medicaid and Long-Term Care and the Division of Developmental Disabilities, prepares federal and state reports as required, and prepares the CMS-64 and 372 reports.

(a) Describe the requirements concerning the independent audit of provider agencies.
DD agency-based providers are required by contract to do an annual audit of their operations. These independent audits are submitted to Financial Services and are reviewed by an analyst for any audit findings or exceptions that might affect State payments by or for the provider.

Services that are delivered by independent providers rather than agency-based providers do not require an independent audit. Independent providers are required to retain financial and statistical records to support and document all claims.

(b) Describe the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits. Claims for all services are audited in the same manner.

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DD waiver providers submit billings through a web-based electronic authorization and claims processing system. A pre-audit of all provider claims is completed to assure the accuracy of coding and billing. Supporting electronic documentation, including staff timecards, participant attendance records or activity schedules, program data records, or other documentation as determined by the Division must be available to Division staff upon request. The provider must maintain electronic or paper records and documentation in sufficient detail, such as staff timesheets and location of service provision, to allow state program accuracy staff to verify delivery of service to participants as certified on the electronic claim.

Independent providers that choose to submit their claims non-electronically must document on the billing document, the type of service provided, the times each service was provided, and the dates the service(s) were provided to each participant. The billing document is signed by the waiver participant or, if applicable, the family member/guardian and forwarded to DHHS staff for processing. An electronic signature is acceptable.

Audits of provider claims may be conducted in response to concerns raised by a review of electronic data, trending reports, complaints, or certification or licensure reviews. DDD central office staff will review documentation to support the claim for services. This documentation may include, but is not limited to, the provider calendar and corresponding claim, agency staff time sheets and corresponding claims, service authorizations, electronic service utilization data, and the service plan. When issues are found that may be considered fraudulent claims; those issues are referred to the DHHS Medicaid Surveillance and Utilization Review Unit, or the Medicaid Fraud Control Unit of the Nebraska Department of Justice Office of the Attorney General.

DDD also conducts internal quality assurance activities related to the use of funding. Billing and authorization data is queried monthly to track trends in costs and service use by area, provider and statewide.

Financial Services track the use of Medicaid funding and provide monthly updates on the use of waiver funding relative to the budgeted amounts. This aids DDD in determining the efficacy of efforts to enhance our monitoring and oversight of the use of waiver funding.

(c) Describe the agency (or agencies) responsible for conducting the financial audit program.
The State Auditor and DHHS are responsible for conducting these financial audits. The Nebraska Auditor of Public Accounts is responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act. The State Auditor conducts the audits on an annual basis.

Quality Improvement: Financial Accountability

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

   i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

Number and percent of paid claims reviewed that were coded in accordance with the reimbursement methodology specified in the approved waiver. Numerator: Number of paid claims reviewed that were coded in accordance with the reimbursement methodology specified in the approved waiver. Denominator: Number of paid claims reviewed.

Data Source:
☒ Record reviews: on and off site

Paid Claims Reviewed

Responsible Party of data collection/generation (*check each that applies)*	Frequency of data collection/generation (*check each that applies*)	Sampling Approach(*check each that applies*)
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒Representative Sample: Confidence Interval= 95% with +/- 5% margin of error
☐ Other *(specify)*	☐ Annually	☐ Stratified: Describe Group
	☒ Continuously and Ongoing	☐ Other *(specify)*
	☐ Other (*specify)*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (*check each that apply*)	Frequency of data aggregation and analysis (*check each that apply*)
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Agency	☒ Quarterly
☐ Other (*specify)*	☐ Annually
	☐ Continuously and Ongoing
	☐ Other: (*specify*)

Number and percent of paid claims reviewed which were in accordance with the reimbursement methodology specified in the approved waiver. Numerator = Number of paid claims reviewed which were in accordance with the

reimbursement methodology specified in the approved waiver. Denominator = Number of paid claims reviewed.

Data Source:
☒ Record reviews: on and off site

Paid Claims Reviewed

Responsible Party of data collection/generation (*check each that applies)*	Frequency of data collection/generation (*check each that applies*)	Sampling Approach(*check each that applies*)
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒Representative Sample: Confidence Interval= 95% with +/- 5% margin of error
☐ Other *(specify)*	☐ Annually	☐ Stratified: Describe Group
	☒ Continuously and Ongoing	☐ Other *(specify)*
	☐ Other (*specify)*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (*check each that apply*)	Frequency of data aggregation and analysis (*check each that apply*)
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Agency	☒ Quarterly
☐ Other (*specify)*	☐ Annually
	☐ Continuously and Ongoing
	☐ Other: (*specify*)

b. Sub-assurance: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

Number and percent of providers reviewed for whom rate changes were consistent with the approved rate methodology. Numerator = Number of providers reviewed for whom rate changes were consistent with the approved rate methodology. Denominator = Number of providers reviewed.

Data Source:
☒ Record reviews: on and off site
Providers reviewed

Responsible Party of data collection/generation (*check each that applies*)	Frequency of data collection/generation (*check each that applies*)	Sampling Approach(*check each that applies*)
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample: Confidence Interval= 95% with +/- 5% margin of error
☐ Other *(specify)*	☐ Annually	☐ Stratified: Describe Group
	☒ Continuously and Ongoing	☐ Other *(specify)*
	☐ Other (*specify)*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (*check each that apply*)	Frequency of data aggregation and analysis (*check each that apply*)
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Agency	☒ Quarterly
☐ Other (*specify)*	☐ Annually
	☐ Continuously and Ongoing
	☐ Other: (*specify*)

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Financial accountability is a joint responsibility of the Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) with assistance from Financial Services staff within DHHS Operations.

Quarterly off-site file reviews are conducted by DDD program accuracy staff (PAS). This review is conducted on a sample of files to ensure activities are being applied correctly, and that reviews and remediation activities are completed as assigned. The sample size for this review is determined by 1) Using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50% OR 2) Using a risk-based quality control sampling plan based on MIL-STD-1916 or ANSI/ASQ Z1.4. PAS are responsible for reporting all individual problems requiring remediation identified during discovery processes to supervisory staff.

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This information is summarized and reviewed by the DDD Quality Improvement Committee (QIC) quarterly.

An independent statewide single audit of DHHS is conducted by the State Auditor of Public Accounts (APA) office on an annual basis following each state fiscal year (July 1 - June 30). This is an audit of the financial statements of the governmental activities, the business-type activities, the aggregate discreetly presented component units, each major fund, and the aggregate remaining fund information of the State of Nebraska. The final report includes APA's findings, DHHS management responses and corrective action plans, if applicable. Financial services staff respond to findings related to the State's accounting systems. DDD staff responds to findings related to review of randomly selected participant waiver files.

The APA reviews the waiver files for compliance with the state's regulations. Each waiver file must include the waiver consent form, Service Plan, documentation of annual physical exam, service authorization form and waiver review worksheets. The APA office also requests a copy of the billing document and NFOCUS service authorization that corresponds with the service dates being tested. The authorization and billing documents are checked for accuracy of service codes and service rates, as well as for agreement with the ISP documentation. Please see Appendix I-1, I-2.b-d, I-3, and I-5 for additional information on strategies employed by the state for checks and balances and discovery of systemic issues.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems that allow for systematic oversight of services across the state by the QIC, while ensuring utility of the information at the local service coordination level. Quarterly reporting has been developed to ensure regular review of the results of the various QI functions. The report shows an empirical data review of results and recommendations for remediation, both to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The participant's DDD Service Coordinator (SC) or Community Coordination Specialist (CCS) has primary responsibility for discovery and remediation of individual problems. Discovery processes include: monitoring; conducting supervisory file reviews; reviewing incidents; and following up on complaints.

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Participants are notified in writing or electronically of the authorized funding amount at the time of choosing a provider and in the development of the ISP. Checks and balances described in I-1, I-2, and I-3 are in place to assure accurate authorizations. The team determines the provider, amount, and type of services needed. The participant's SC/CCS authorizes the services. When discrepancies are found, designated DDD staff take action to correct errors in the authorization, such as correcting the provider, service type, service amount, and/or dates of services. A pre-audit of all provider claims is completed to assure the accuracy of coding and claim. NFOCUS, Nebraska's electronic system for authorization and claims processing, was designed to meet the CMS requirements and the HCBS DD waiver specifications.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis

Responsible Party for data aggregation and analysis (*check each that apply*)	Frequency of data aggregation and analysis (*check each that apply*)
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Agency	☐ Quarterly
☐ Other (*specify)*	☒ Annually
	☒ Continuously and Ongoing
	☐ Other: (*specify*)

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ **No**

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Developmental Disabilities Division (DDD) contracted with Navigant Consulting, Inc. (Navigant) to develop a rate modeling process for fee-for-service rates for DDD's HCBS waivers. DDD built the proposed rates upon the estimated average cost of care incurred by providers administering developmental disabilities (DD) services statewide. Each DD service has its own individual rate build-up model. The model begins with a current estimate of the cost of labor required to provide the specific service. The rate that accounts for the total cost of the service is

determined by applying factors to this base labor cost. The ultimate goal was to develop a rate that is reflective of the average overall cost to administer DD services on a unit basis.

As described in the Introduction and Appendix C of this Waiver, DDD unbundled services to align with federal regulation and to pay for and record services more accurately. The unbundling process required new service definitions and rates. The unbundling timeframe did not allow for a comprehensive rate rebasing. In lieu of this, rate setting was accomplished using cost data (items of expenditure reflected on providers' general ledgers) from a provider survey collected in 2010 to establish cost factors (e.g. administrative, program support, transportation, and employee benefits) to apply to base wage assumptions from the first quarter in 2016. This approach was amenable to providers as it provided for an inflation rate in the cost factors equal to that observed in the base wage. DDD solicited feedback from Stakeholders (in bi-weekly rate setting workgroup sessions, monthly provider trade association meetings, monthly Stakeholder meetings and frequent ad hoc meetings with providers) to inform and validate assumptions in the rate model.

Nebraska will begin to reexamine rates in December 2016. An Amendment to this waiver for the prospective rate methodology will be submitted to CMS upon completion. Upon approval of the new rate methodology, the new rates will be implemented. Thereafter, Nebraska will reexamine rates at least every five years, upon renewal of its waivers. At the time of each biennium budget request, DDD examines the need for rate adjustments or rebasing. Prior to this rate adjustment, DDD rebased DD HCBS rates in 2011. When the State Legislature appropriated funds, the rates were implemented in July 2014.

DDD developed rates specific to independent providers based on stakeholder feedback and the goal to provide more services to be able to be purchased with the participant's prospective individual budget amount. DDD established independent provider rates in the proposed rates to reflect additional habilitation opportunities for self-directed services and provider qualifications for habilitative services. The rate models for independent providers have different assumptions to compensate for differences compared to agency providers (e.g. independent direct care workers require a bachelor's degree, there are no supervisory costs, and lower administrative costs).

DDD also changed the rate structure for certain services from 11 levels to 4 tiers. These tiered rates were a result of provider feedback to reduce billing complexity. Certain cost factors vary by tier within a given service. The following services have a tiered rate: Habilitative Community Inclusion and Habilitative Workshop. The reimbursement for these services are tiered based on participant's level of service need as determined by the ICAP assessment. The 4 reimbursement tiers are:

- Basic-ICAP levels 7 - 11.
- Intermediate-ICAP levels 4-6.
- High–ICAP levels 2 and 3.
- Advanced–ICAP level 1.

A more detailed description of these tiers and the Objective Assessment Process (OAP) is provided in the MAIN-B-Optional section.

The cost factors used to determine rates are described in the list below.

A. Direct Care Staff Cost: This factor represents the hourly cost of direct care staff for a service. It is based on a "blended" wage model that considers variation in the skill level and compensation of staff providing the service. Hourly wage assumptions in this model are listed below along with a parenthetical reference to the basis of the estimate.
   a. Direct Care Worker:$13.10 (Beatrice State Developmental Center a.k.a. BSDC wage data, more detail on why this data source was used is provided in MAIN-B-Optional)
   b. Direct Care Worker-Overnight Asleep:$9.00 (NE minimum wage)
   c. Advanced Direct Care Worker:$16.05 (BSDC wage data)
   d. Direct Care Trainers:$14.75 (BSDC wage data)
   e. Supervisor:$17.42 (BSDC wage data)
   f. Independent Provider Direct Care Worker:$16.05 (BSDC wage data)
   g. Vocational Trainer: $16.05 (BSDC wage data)
   h. Behavioral Health Bachelor's Level:$40.65 (OMNI Behavioral Health wage data, more detail on why this data source was used is provided in MAIN-B-Optional)
   i. Respite:$11.23 (from 2010 provider survey wages, updated for inflation and increase to NE minimum wage)

B. Assumed Staffing Ratios (Awake): Number of direct care staff required to provide services. Staffing Ratios vary based on level of service need for tiered services.

C. Benefits: This factor compensates providers for benefits (FICA taxes, health insurance, retirement, etc.) provided to employees. This factor is set at 30.28%.

D. Productivity Factor: This provides for expenses related to non-billable activities (e.g. individual support plan meetings, travel time between clients, record keeping, staff meetings, program development, etc.). The factor is based on the estimated proportion of a work week spent in non-billable activities and varies by service type.

E. FTE Factor: This provides for expenses related to paid time off (PTO) and an allowance for staff to attend training. The factor assumes 17 days for PTO and 7 for training. Considering these 24 days as 192 hours (8 hours/day) and applying a conventional 2,080 hours (52 weeks times 40 hours/week) assumption for an FTE, the factor is calculated at 9.23% (192/2,080).

F. Supervisor wage factor: Hourly wage of supervisory staff ($17.42).

G. Supervisor Span of Control: The ratio of supervisors to direct care workers. This is 1:9 for all services with the exception of the advanced tiers where it is 1:6. The basis for this delineation was provider feedback that direct care staff supervising these participants require a greater level of supervision.

H. Administrative: These expenses include administrative employees' (management, accounting and finance, human resources, etc.) salaries and wages, non-payroll administrative expenses (other administrative costs including background checks, recruiting, and training), and contracted administrative services (expenditures for contracted administration services for management fees, clerical support, information technology support, professional service fees, legal expenses/attorney fees or other contracted administration services). This factor is 19.60% for Agency providers. For independent providers, only non-payroll administrative expenses are considered and a reduced factor of 4.02% is used.

I. Program Support: Expenses that are part of the operation of the setting in which services occur and related to the programs which occur within the setting, but are not directly tied to the direct care staff. They include program management and program operational expenses. This factor is 10.76%.

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J. Transportation: In order to clearly delineate transportation costs so providers understand when a rate included costs of transportation, a separate transportation factor was created using costs related to vehicles owned or operated by providers, as reported on the 2010 cost and wage survey. This factor is 6.20%.
K. Incentive Adjustment Factor: This factor was incorporated in certain services that align with Nebraska's DDD vision to promote community inclusion and encourage competitive/integrated employment. These services include Habilitative Community Inclusion, Prevocational, and Supported Employment services provided by agencies.
L. Reduction Adjustment Factor: This factor reduces rates for certain services. This factor is applied to certain services provided by 1) independent providers to better align the rates with the current individual budgets for services and 2) to other services to achieve budget neutrality (i.e. align rates with those in effect for similar services on July 1, 2016).

Environmental Modification Assessment, Transitional Services, Assistive Technology, Vehicle Modification and Home Modifications are approved on a per case basis. Costs for services approved and service cap limits are reviewed annually.

Reimbursement for Transportation service is based on the Nebraska standard for mileage reimbursement, pursuant to Neb. Rev. Stat. 81-1176.

Information about payment rates is made available verbally and in writing to waiver participants and providers by state DHHS staff. The waivers and rate study are posted on the DHHS public website at http://dhhs.ne.gov/medicaid/MedicaidWaiverInitiative/Pages/Home.aspx.

I-2: Rates, Billing and Claims

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings flow from providers to the State's claims translator and downloaded to N-FOCUS, the State's electronic local web-based service systems, which is a component of MMIS, and are not routed through intermediary entities. Services are prior authorized and sent electronically to the provider in a vendor web-based service system. Service data is recorded in the attendance module and a claim is generated through the vendor web-based system by providers and are electronically submitted for claims processing following the delivery of services. Billings may be submitted on paper claims and flow from providers to a designated DHHS e-mail mailbox for manually processing through the state's systems.

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services are authorized. During nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program.

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This information is summarized on a voucher that is then sent to the state's accounting system, the Nebraska Information System (NIS).

All claims are routed through the N-FOCUS sub-system, a recognized component of MMIS, and are subsequently sent to the Nebraska Information System (NIS), the accounting system for the State of Nebraska.

The program under which a claim is paid is stored on each individual service authorization and electronically transferred to the claim. For each program, a separate account is maintained from which to debit the federal and state shares based on the date of payment. Those account tables are maintained over time. When the payment is made, all claims for the same program are then summarized on a voucher and submitted to the Nebraska Information System (NIS). N-FOCUS stores the timestamp and user ID for all new or updated information related to this process.

Federal funds are drawn from the designated accounts at the time an approved claim is set to Paid status and sent to the Nebraska Information System (NIS). Claims are processed on a daily basis.

Direct billing of waiver services is provided to the State. Claims made to Medicaid are documented on the CMS-64 on a quarterly basis.

I-2: Rates, Billing and Claims

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the participant was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a) Claims for payment are made only when the participant was eligible for a Medicaid waiver payment on the date of service.
Waiver services must be prior authorized before payment is made. Authorizations are based upon a determination by designated DDD staff (Disability Services Specialists and DDD Service Coordination staff) that the participant meets waiver eligibility criteria, that the services are identified in the approved service plan, and that the services are not available for funding through programs funded under section 602 (16) or (17) of the Individuals with Disabilities Education Act (P.L. 94 - 142) or section 110 of the Rehabilitation Act of 1973.

b) Claims for payment are made only when the service was included in the participant's approved service plan.
The authorization and payment process includes the following steps:
1. Waiver eligibility of the participant is determined.
2. Waiver services are identified in the service plan.

3. Waiver service authorization, also known as the budget authorization, is completed, indicating approved waiver services, waiver provider(s), dates of service, and authorized units of service.
4. Authorization is entered into in a vendor web-based service system used for budget authorization, claims processing, and case management and then sent to NFOCUS, the state's electronic local web-based authorization and payment system.
5. Upon verification through the vendor web-based system, claims are electronically submitted to NFOCUS for processing. Edits in the vendor web-based system verify participant and provider eligibility, dates of service, units of service, and rates.
6. Claims are generated based on service data entered by providers.

c) Claims for payment are made only when the services were provided.
In addition to enrollment as a Medicaid provider, all providers must sign an annual Service provider agreement and addendum as applicable, stipulating that the provider shall maintain records and documentation in sufficient detail to allow state staff to verify units of service provided to participants as certified on the state billing document. Each billing document must be signed by the provider, certifying that the foregoing claim is accurate and all services provided were in compliance with applicable state regulations.

When services are delivered by an independent provider, a description of services must be submitted on the billing document and signed by the waiver participant or, if applicable, the family member/guardian. The billing document is forwarded to DHHS staff for processing. An electronic signature is acceptable.

The billing validation process verifies that the participant was eligible for Medicaid waiver payment on the date of service.

I-3: Payment (1-7)

a. **Method of payments – MMIS**

☒Payments for all waiver services are made through an approved MMIS.
☐Payments for some, but not all, waiver services are made through an approved MMIS.
☐Payments for waiver services are not made through an approved MMIS.
☐Payments for waiver services are made by a managed care entity or entities.

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☒ The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

☐ The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid Program.

☐ The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

☐ Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

☒ **No.** The State does not make supplemental or enhanced payments for waiver services.

☐ **Yes**. The State makes supplemental or enhanced payments for waiver services.

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

☐ **No.** State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

☒ **Yes.** State or local government providers receive payment for waiver services. Complete Item I-3-e. Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Vocational Rehabilitation Services within the Department of Education is a state government agency. Vocational Rehabilitation Services is an independent waiver provider of Assistive Technology, Home Modifications, Vehicle Modifications, and/or Environmental Modification Assessment, and receive the same rates as all providers for those services.

In Nebraska, some agency-based DD providers are public providers established by County Commissioners under interlocal agreements. Both private and public agency-based DD providers deliver the same waiver services, and the payment to these public providers does not differ from the amount paid to private providers.

e. **Amount of Payment to State or Local Government Providers.** Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

☒ The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.

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☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs or providing waiver services.

☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

☒ Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

☐ Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

☒ **No.** The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

☐ **Yes.** Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

ii. **Organized Health Care Delivery System.** *Select one:*

☒ **No.** The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

☐ **Yes.** The waiver provides for the use of Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

☒ The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

☐ The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plans(s) (PIHP) or prepaid ambulatory health plans(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

☐ This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The

§1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

I-4: Non-Federal Matching Funds (1 - 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☒ Appropriation of State Tax Revenues to the State Medicaid agency.
☐ Appropriation of State Tax Revenues to the State Medicaid agency other than the Medicaid Agency.
☐ Other State Level Sources of Funds.

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
☐ **Applicable.** Check each that applies: ☐Appropriation of Local Government Revenues.
☐Other Local Government Level Sources of Funds.

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

☒ None of the specified sources of funds contribute to the non-federal share of computable waiver costs.
☐ The following sources are used. Check each that applies:
- ☐ Health care-related taxes or fees
- ☐ Provider-related donations
- ☐ Federal funds

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

☒ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The state establishes the rates for waiver services furnished in residential settings and those rates do not include any costs for room and board. The providers bill according to the established rates.

In Nebraska, the participant's SSI payment is used for room and board. The service rates reflect the exclusion of Medicaid payment for room and board for services that are delivered in residential settings. Room and board costs are excluded from the rates for Residential habilitation, In-home Residential service, and Companion service.

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

☒ **No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

☒ **No.** The State does not impose a co-payment or similar charge upon participants for waiver services.

☐ **Yes.** The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay arrangement. Specify the types of co-pay arrangements.

ii. - iv. Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

☒ **No.** The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

☐ **Yes.** The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

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